



Healthy Marriages
"Supporting Relationships ~ Strengthening Families!"

HM REFERRAL FORM

Referral for:

Date:

Street Address:

Phone:

City:

State:

Zip:

Cell:

Please check appropriate boxes, this is for: ☐ Individual ☐ Couple ☐ Family ☐ Youth ☐ Adult

Best time to contact:

Best day/time to schedule an appointment:

PROGRAM INFORMATION: What Program/Department made referral to Healthy Marriages Program?

☐ YESS

☐ CARE/Suboxone

☐ TANF/VR/GA/ETC

☐ Victims of Crime

☐ Children Services/ICW

☐ Lummi Indian Health

☐ Tribal Court

☐ Probation

☐ Public Defender

☐ Tribal School

☐ Head Start

☐ Youth Recreation

☐ NWIC

☐ Housing

☐ LNN/SQ/Community Event

☐ Friend/Family

☐ Other: _____

Please describe issues/problems of concern:

Please list how many children, and their age/gender:

Please describe, how does it make you feel, and the severity of this matter on a scale of 1-10, 1-low 10-high:

Please list the name of person you were referred by:

Signature:

For Office Use Only

Case assigned to MFT:

Received by:

Date: